MONTANA
Department of Public Health & Human Services

**May 9, 2006**

# Revised Montana Medicaid Notice

## Outpatient Prospective Pay Hospital

## Changes in Observation Billing

**This notice supercedes the observation notice originally issued January 1, 2006. Please note that critical access and exempt hospitals are not affected by these new instructions concerning observation billing.**

**Effective January 1, 2006**

Beginning January 1, 2006, the Outpatient Claim Editor (OCE) will determine if a claim qualifies for observation reimbursement (APC 0339). Because of this change, claims must be coded differently.

Effective January 1, 2006, codes G0244, G0263, G0264 and 99217-99220 will be discontinued. Codes 99234-99236 may be used for Obstetric Observation ***only***.

Code G0378 will be used to report hospital observation care for patients admitted through an outpatient setting such as emergency room, critical care clinic or provider-based clinic. Code G0379 will be used to report hospital observation care for patients directly admitted without an associated emergency room, hospital outpatient clinic or critical care service on the day of admission. Code G0379 is to be used only when a patient is admitted directly to observation care after being seen by a physician in the community.

### Outpatient Admissions to Observation

All services must be reported on a 13X bill type. Code G0378 should be reported with the first date of admission to an observation bed. Total hours of the observation visit should be reported on this line regardless if the visit spans more than one date. All other services associated with the observation service must be billed on separate lines with the appropriate CPT/HCPCS codes and appropriate revenue centers. You must bill a unique E/M or critical care (C/C) visit on a separate line with this code. Modifiers should be used where required.

The OCE will determine if the claim qualifies for separate observation payment (APC 0339) or if it is to be bundled (status indicator "N") into other payable services for that date of service. If the admission is a qualifying observation, both the associated E/M or C/C visit (APCs 0600-0602, 0610-0612 and 0620) and the observation are paid separately. Codes with a status indicator of "T" on the day before or the same date of service will cause the observation line to bundle.

### Direct Admissions to Observation

All services must be reported on a 13X bill type. Both code G0379 (Direct Admit) and code G0378 (Hourly Observation) should be reported with the first date of admission to an observation bed. One (1) unit of service is reported on G0379. Total hours of the observation visit should be reported

on the line with G0378 regardless if the visit spans more than one date. All other services associated with the observation service must be billed on separate lines with the appropriate CPT/HCPCS codes and appropriate revenue centers. Modifiers should be used where required.

The OCE will determine if the claim qualifies for observation payment (APC 0339) or if it is to be bundled into other payable services for that date of service. Codes with a status indicator of "T" or "V" (E/M or C/C visits) on the day before or the same date of service will cause the observation line to bundle.

### Obstetric Observation

All services must be reported on a 13X bill type. Do ***not*** use codes G0378 or G0379. Use codes 99234-99236 to report Obstetric Observation. Total hours of the observation visit should be reported on the line with 99234-99236 regardless if the visit spans more than one date. All other services associated with the observation service must be billed on separate lines with the appropriate CPT/HCPCS codes and appropriate revenue centers. Modifiers should be used where required.

The MMIS will determine if the claim qualifies for observation payment (APC 0339) or if it is to be bundled into other payable services for that date of service.

### Qualifying Observation

The patient must have one of four medical conditions: congestive heart failure, chest pain, asthma or obstetric complications. Qualifying diagnosis codes must be in either Admitting Diagnosis (Form Locator 76) or Principal Diagnosis (Form Locator 67). (See Outpatient Billing Guide under Other Resources at www.mtmedicaid.org for a listing of qualifying diagnosis codes.)

Qualifying observation time for code G0378 must be at least 8 hours but no more than 72 hours. Qualifying observation time for 99234-99236 must be at least 1 hour but no more than 8 hours. ***Even if you believe the service is not a qualifying observation service, you must bill it with the appropriate observation codes.***

For qualifying outpatient admits, no procedure with a "T" status indicator can be reported on the same day or day before. For direct admits, no procedure with a "T" or "V" (E/M or C/C visits) can be reported on the same day or day before.

Only observation services that are billed on a 13X bill type may be considered for separate APC payment for in-state, out-of-state and border facilities.

## Contact Information

For claims questions or additional information, contact Provider Relations:

**Provider Relations toll-free in- and out-of-state: 1-800-624-3958**
**Helena: (406) 442-1837**

Visit the Provider Information website:

**http://www.mtmedicaid.org**